

2211 E. Northern Lights BLVD
 Anchorage AK 99508
 Phone: (907) 257-8123
 Fax: (907) 677-5611



Hours:
 Monday-Friday 7:30AM – 6PM
 Located in Charter North Building

Referral/Medical Authorization Form

SECTION 1: EMPLOYER REFERRAL INFORMATION

Company	COMPANY		
Physical Address			
Designated Employee Rep. (DER)			
DER Phone	(907)	DER Fax	(907)
DER Email			
Preferred method of contact	<input type="checkbox"/> Phone <input type="checkbox"/> Email <input type="checkbox"/> Fax		
Project ID/JOB #	LOCATION:		
Referral Date:		Valid through	

SECTION 2: PATIENT DATA

Name (Last, First, MI)	
SSN/ID #	Date of Birth:

SECTION 3: OCCUPATIONAL HEALTH SERVICES REQUESTED

<input type="checkbox"/> Hazwoper Annual/Baseline/Semi-Annual	<input type="checkbox"/> Physical Fitness Test (Tier 1, Tier 2, Tier 3)
<input type="checkbox"/> DOT CDL Physical	<input type="checkbox"/> Respirator fit test (Specify Mask type below)
<input type="checkbox"/> Post-Offer Physical - Basic	<input type="checkbox"/> Pulmonary Function Test (PFT)
<input type="checkbox"/> FAA Physical	<input type="checkbox"/> Vision - Standard
<input type="checkbox"/> Divers Physical	<input type="checkbox"/> Vision w/Depth Perception
<input type="checkbox"/> Coast Guard/Merchant Marine Physical	<input type="checkbox"/> Asbestos Annual/Baseline
<input type="checkbox"/> Fit for Duty/ Work Release	<input type="checkbox"/> Special Instructions/Other Testing (Specify Type of Test)
<input type="checkbox"/> Respiratory Medical Exam w/ Chest X-ray	<input type="checkbox"/>
<input type="checkbox"/> Audiometry (Baseline) (Annual) (30 Days Noise free)	<input type="checkbox"/>

SECTION 4: DRUG & ALCOHOL SERVICES REQUESTED

DRUG PANEL:	LAB ACCOUNT:	REASON FOR TESTING:	
<input type="checkbox"/>		<input type="checkbox"/> Pre-Employment	<input type="checkbox"/> Reasonable Suspicion RC
<input type="checkbox"/>		<input type="checkbox"/> Post-Accident PA	<input type="checkbox"/> Return-to-Duty
<input type="checkbox"/>		<input type="checkbox"/> Random	<input type="checkbox"/> Follow-Up
<input type="checkbox"/>		<input type="checkbox"/> Non-DOT Breath Alcohol	<input type="checkbox"/> DOT Breath Alcohol Test
<input type="checkbox"/>		<input type="checkbox"/> Direct Observation Required	

SECTION 5: LAB/IMMUNIZATION/OTHER SERVICES

<input type="checkbox"/> Complete Blood Count	<input type="checkbox"/> Basic Metabolic Panel	<input type="checkbox"/> Comprehensive Metabolic Panel	<input type="checkbox"/> Vaccination Tetanus-DT	<input type="checkbox"/> PPD/TB Test
<input type="checkbox"/> Urinalysis	<input type="checkbox"/> Influenza (Flu)	<input type="checkbox"/> Hepatitis A&B (Twinnrix)	<input type="checkbox"/> Lead Blood	
<input type="checkbox"/> Urinalysis Micro	<input type="checkbox"/> Lipid	<input type="checkbox"/> Vaccination Hep A	OTHER (Specify)	
<input type="checkbox"/> EKG	<input type="checkbox"/> Chest X-Ray	<input type="checkbox"/> Vaccination Hep B		
Authorized Representative Signature:			Date:	

**Insure Donor/Patient BRINGS PHOTO ID With Form or
 Fax to: (907) 677-5611 OR Email to: occupationalhealth@mpfcak.com**